ST JOSEPH'S HEALTH CARE LONDON

COORDINATED ACCESS REFERRAL FORM

Parkwood Institute
Mental Health Care Building
550 Wellington Rd. S.
London, ON N6C 0A7
Tel: 519-646-6425 Ext. 48000
Fax: 519-646-6426

ATTACHMENTS:

- ☐ **CURRENT LEGAL FORMS**
- ☐ ADULT NEEDS & STRENGTHS ASSESSMENT *(ANSA-R – REQUIRED FOR ALL REFERRALS)*
- ☐ RAI-MH *(IF ATTACHING, COMPLETE SECTIONS A, B, C, E AND G ONLY)*
- ☐ COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
- ☐ NURSING NOTES
- ☐ CURRENT MEDICATION ADMINISTRATION RECORD
- ☐ OT/PSYCH/SW ASSESSMENTS ☐ CARE PLANS
- ☐ CURRENT PHYSICIAN'S NOTE
- ☐ ADOLESCENT DBT/OUTREACH PROGRAM ☐ CRISIS/SAFETY PLAN

SECTION A

NAME OF CLIENT _____
(LAST/FAMILY NAME) (FIRST NAME) (MIDDLE/INITIAL)

DOB: | | | | | | | | | HEALTH CARD #: | | | | | | | | | | VERSION _____

AGE: | | SEX: ☐ M ☐ F ☐ T CURRENTLY IN HOSPITAL? ☐ Yes ☐ No If Yes, admission date: | | | | | | | |
Y Y Y Y M M D D

STATUS: ☐Voluntary ☐ Involuntary MARITAL STATUS: ☐Single ☐Married ☐Common-law ☐Widowed ☐ Divorced ☐ Separated

ADDRESS _____ Telephone: | | | | | | | | | | | |
(STREET) (CITY/TOWN/POSTAL CODE)

Next of Kin: _____ Relationship _____ Telephone: | | | | | | | | | | | |

Family Physician: _____ Telephone: | | | | | | | | | | | |

Community Psychiatrist: _____ Telephone: | | | | | | | | | | | |

Other community supports (natural/formal):_____ Telephone: | | | | | | | | | | | |

_____ Telephone: | | | | | | | | | | | |

_____ Telephone: | | | | | | | | | | | |

SECTION B – CURRENT STATUS

Capable to consent to treatment ..... ☐ Yes ☐ No If no, SDM: _____ Tel: | | | | | | | | | | | |

Capable to manage property..... ☐ Yes ☐ No If no, guardian:_____ Tel: | | | | | | | | | | | |

Capable to disclose info. related to clinical record.. ☐ Yes ☐ No If no, SDM: _____ Tel: | | | | | | | | | | | |

Legal Guardian for referred adolescent (if applicable): _____ Tel: | | | | | | | | | | | |

Is client or SDM (if applicable) aware of and in agreement with referral for admission? ☐ Yes ☐ No

Is client's family aware and in agreement? ☐ Yes ☐ No ☐ N/A

SECTION C – REFERRAL GOALS

	Client	Client's Family	Referral Source
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

SECTION D

PSYCHIATRIC DIAGNOSES: _____

_____

MEDICAL DIAGNOSES: _____

_____

PSYCHOSOCIAL STRESSORS: _____

_____

RESIDENTIAL STATUS: ☐ Private home/apt ☐ Assisted living/group home ☐ Long-term care facility

☐ Repatriate to Community Hospital ☐ Homeless (with or without shelter) ☐ Other _____

CLIENT CAN RETURN POST-DISCHARGE? ☐ Yes ☐ No SOURCE OF INCOME: _____

CURRENT LEGAL STATUS: ☐ No legal problems ☐ Currently on probation/ parole ☐ Recently incarcerated

☐ Currently in a court diversion/support program ☐ Restraining order(s) present ☐ Outstanding charge(s) _____

☐ Community Treatment Order ☐ Student (School Name)_____

SECTION E

Client has a past history of suicide ideation/attempts? ☐ Yes ☐ No Client has a past history of violence? ☐ Yes ☐ No

If yes, details required _____

_____

Is client currently suicidal? ☐ Yes ☐ No Is client currently violent? ☐ Yes ☐ No

If yes, details required _____

_____

☐ Non-ambulatory or assisted ambulation ☐ Blindness/vision impairment ☐ Learning disability ☐ Seizures

☐ Language/cultural ☐ Deafness/hearing loss ☐ Cognitive impairment ☐ Other (specify) _____

☐ Speech impairment ☐ Incontinence ☐ Head injury _____

SECTION F

Number of psychiatric admissions in the last two years: _____ (If # of admissions > 0, Number of days in psychiatric hospital/unit in the last two years: _____)

Number of months since discharge from last mental health admission: _____ or ☐ Not applicable

Number of days since last contact with a community mental health agency or mental health professional in the past year: _____ or ☐ No contact in last year

SECTION G – MEDICATIONS

☐ Current MAR attached **OR** ☐ List of all active prescriptions attached

Referral form completed by: _____ Title: _____

Organization: _____

Telephone: ☐☐☐☐☐☐☐☐☐☐ Ext: ☐☐☐☐☐ Fax: ☐☐☐☐☐☐☐☐☐☐

Signature: _____ Date Completed: ☐☐☐☐☐☐☐☐ (Y Y Y Y M M D D)